Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

PERFORMANCE MEASUREMENT WORKGROUP #1
CONCEPTUAL DESIGN
WEDNESDAY, MAY 4, 2005
RED LION INN, SACRAMENTO

Meeting Summary
For Discussion Only

Table of Contents

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond 'business as usual' to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

This series of three workgroup meetings addresses performance measurement. This first meeting focused on the conceptual design of performance measurement. The second meeting will be held on June 16 and the final workgroup in the series will be held on July 18.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the afternoon workgroup session purpose, review the workgroup agenda, ask questions, provide feedback and network with each other. The workgroup was held from 1:00 – 4:00 p.m. Both the pre-meeting and the workgroup session were introduced with the same general overview, which is summarized below in the Background section.

Forty-seven (47) people attended the morning CFM pre-meeting and 104 attended the afternoon workgroup meeting.

A. Meeting Purpose

The outcomes of the workgroup meeting were to:

1. Provide information about the conceptual framework for performance measurement under MHSA.

2. Solicit feedback from stakeholders to the Department of Mental health about the performance measurements.

B. Schedule of Meetings

Upcoming workgroup dates are:

- The remaining Performance Measurement Workgroup sessions are scheduled on June 16 and July 18. The conference call dates will be posted on the MHSA website, www.dmh.ca.gov/MHSA.
- Stakeholder meetings on the revised DRAFT CSS Requirements will be held on June 1 in Sacramento and June 3 in Los Angeles. The conference call date will be posted on the MHSA website.
- Other workgroup meetings will be scheduled soon and the dates and workgroup topics will be posted on the MHSA website.

C. Update on MHSA Progress since April 5 & 6 General Stakeholders Meetings

Carol Hood, DMH Deputy Director, provided a brief update on what has happened in MHSA since the General Stakeholders meetings held on April 5 and 6 in Los Angeles and Sacramento.

She announced that the revised Community Services and Supports (CSS) Requirements are scheduled to be released in draft form on May 15. There will be stakeholder meetings on June 1 (Sacramento) and June 3 (Los Angeles) to provide input on the new draft. The document has undergone considerable change since stakeholders last reviewed it.

Ms. Hood noted that the issue raising the highest passions was involuntary care. She reported that no decisions on involuntary services have been made yet, although discussions continue. The Department recently heard an eloquent presentation from the Client Network. They made excellent points about legal status for those who are under conservatorship or under the control of their parents or guardians. Currently, DMH is looking at the issue from two perspectives: 1) whether the program or service is primarily voluntary or involuntary, and 2) the legal status of the person receiving services. The Department will indicate any proposed changes in the requirements regarding the use of MHSA funding for involuntary services in the next draft of the CSS Requirements.

Counties have submitted requests for planning funds. Almost all have been approved, some with conditions. The planning processes have started in many counties and DMH has been getting feedback from the local efforts. Ms. Hood noted that DMH has come to believe that the major vehicle for transformation will occur at the local level and an inclusive, effective planning process is critical for the changes to occur.

The Department is working on the planning estimates for how much funding each county can apply for. Counties are asking for information for a funding range in order to

properly plan. These planning estimates will be released in final form as soon as they are ready.

DMH has been working on the MHSA components of Capital Facilities and IT and of Education and Training. These areas will be the topics of workgroups in June and July. The Department has not begun work on the two MHSA components of Prevention or Innovation.

Ms. Hood said that there has been no announcement from the Governor's Office about the composition of the Oversight and Accountability Commission, although there are indications that it will be imminent. DMH has hired David Dodds as Interim Executive Director of the Oversight and Accountability Commission.

D. Performance Measurement Conceptual Framework

Ms. Hood introduced Stephanie Oprendek, Ph.D., Chief, DMH's Performance Outcomes and Quality Indicators Section, who is responsible to design the performance measures to be used by counties. Dr. Oprendek is responsible to assess how IT systems will work to produce results and all other questions related to assessing the impact of MHSA.

Dr. Oprendek made a presentation at both the client and family member pre-meeting and at the afternoon workgroup meeting, using the PowerPoint presentation, *Mental Health Services Act Performance Measurement Conceptual Design*, which can be found on the MHSA website. This presentation was based on the *Draft Preliminary Discussion of the Performance Measurement Design for the California Mental Health Services Act*, dated April 28, 2005, which is also available at the MHSA website.

Dr. Oprendek described the purposes of performance measurement:

- To answer legislative mandates
- To work toward improving quality
- To align management and administrative practices with quality services, productivity and positive outcomes

She then described the process of quality improvement:

- To identify target areas to improve and, in the case of MHSA, to transform
- To design and implement changes to achieve improvement
- To collect and analyze data to measure progress in terms of established goals

Dr. Oprendek discussed the fact that California's mental health system already uses a number of benchmarks and measurement tools, based on funding sources and specific projects. She noted that the MHSA performance measurement design will use the enrollment and tracking concepts of the AB 2034 program to assess client outcomes. These concepts have been successful in evaluating the program and demonstrating the effectiveness of services and supports related to client outcomes.

Next, Dr. Oprendek reviewed the three levels of impact MHSA will use to measure performance: the individual client, the mental health system and the public or community. She then described each component of these levels, as well as examples of how measurements could be used to reflect wellness, recovery and resilience. She described a number of existing tools, some of which are also undergoing revision to reflect changes in perspective.

Dr. Oprendek discussed the need to go beyond the current measurement tools to include multiple measures, with the eventual goal of implementing electronic health records (EHR) that would allow access to more complete information. At the same time, EHR raises questions about security and confidentiality. To begin, the MHSA will use existing information already collected by counties and will develop new measures.

Individual Client Level

Client tracking data include demographic and contact information, tracking of services and billing. DMH will continue to evaluate the information to ensure appropriate focus on wellness and recovery. Much of this information will come from county encounter data systems and will capture who received how many and what type of services. This tracking must be able to capture self-help and peer services.

Individual client outcomes are usually determined using surveys to clients. It is generally considered to be about individual outcomes, but it also can be used to evaluate the mental health system as a whole. AB 2034 experience will be particularly useful at this level, as the program has been successful for tracking key events such as incarceration, homelessness and hospitalization. Periodic tracking of individuals will also include housing, criminal justice engagement, functioning, employment, education, hospitalization, income, entitlements, family preservation, symptoms, suffering, suicide, substance abuse, illness self-management, social/community involvement, individual service plan involvement and physical health. DMH will make a concerted effort to use more positive language than has been used in the past.

Mental Health System Accountability Level

The mental health system accountability level addresses the question as to whether DMH and counties are doing what they said they would do. DMH will monitor local plans, with respect to cultural competence; stakeholder involvement; fidelity to model programs; adherence to budget, staff and providers competence; adherence to appropriate client-to-staff ratio; quality improvement projects; service partnerships; supportive services; coordinated services for co-occurring disorders; costs and cost-effectiveness. Client and family satisfaction can be measured through such indicators as the Mental Health Statistics Improvement Program (MHSIP) indicators and surveys. Staff and provider evaluations, rarely done in the past, will be used to assess such

concerns as coordination of services and interagency collaboration, using interviews and surveys. Some of the individual client tracking will also be used for this level.

DMH is aware of the need not to overburden consumers and staff with paperwork, and will strive to select information that fulfills the MHSA intent. DMH staff will seek a variety of means to get the information for multiple measures.

Public/Community Level

DMH has an obligation to the community and the California voters. The Department wants to promote awareness of mental health issues and wellness in the community, through education, with the goal of lessening stigma and discrimination. Measures for promotion and awareness will be created and systems will track outreach programs to people who are homeless and who live in rural communities, community emergency responses, educational seminars, telehealth, anti-stigma campaigns, community support groups, Public Service Announcements (PSAs) and media that target resilience, recovery and wellness. These activities will be measured by counts or by implementation of systems.

Mental health system structure includes an inventory of what is available in the local community, where the services are located, outreach and mobile services or services in other agencies. This is typically measured by what is called penetration rate, which includes service utilization rates and evaluation of ethnic disparities. Community reaction will be measured through media reviews, public opinion surveys, interviews with public officials and other measures.

Large scale tracking will use community measures of such aggregate indicators as prevalence of mental illness, suicide rates, hospitalizations, incarceration, youth in juvenile justice or foster care, community need and unmet need levels.

Other Examples of Performance Measures

Dr. Oprendek gave several examples of current or recently used performance measures, based on demonstration projects and smaller studies, to illustrate how measures can be interesting but not always useful. She emphasized that these types of measures must be aggregated so that DMH can tell a statewide story that looks at both costs and cost-effectiveness.

Next, Dr. Oprendek discussed Recovery-Oriented System Indicators (ROSI). Many projects are underway to use more recovery-based evaluation measures and many stakeholders are sending valuable information about these projects to DMH.

Finally, Dr. Oprendek discussed Quality of Life indicators. These indicators, while useful, need to be revisited in terms of wellness, recovery and resilience. They have

many shortcomings. MHSA encourages DMH and stakeholders to work on developing a better way to use these measures.

Websites with useful information about recovery-oriented system indicators and other performance measurement issues can be found at:

www.namiscc.org/Recovery/2005/MeasuringRecovery.htm
www.nasmhpd.org/publications.cfm#techreports

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Forty-seven (47) people attended the morning C/FM pre-meeting.

A. Welcome and Introductions

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the client and family member session by reminding people of upcoming dates for the MHSA stakeholder input.

This meeting was the first in a series of three meetings on performance measurements. The second one will be held on June 16 and the third meeting will be on July 18. In between, there will be other workgroup meetings on other topics and General Stakeholder meetings on June 1 and 3. Those meeting topics and dates will be announced soon. Ms. Wunsch encouraged people to check the website for updates.

Ms. Wunsch reviewed the agenda for the afternoon workgroup meeting. First, Carol Hood, DMH, provided an update on progress since the general stakeholders meetings, described in Section I.C., pages 2-3 of this summary. Then Dr. Oprendek presented information on performance measurements, described in Section I.D., pages 3-6 of this summary. Finally, the stakeholders divided into small groups by the four age groups (children and youth, transition-age youth, adults and older adults) to discuss how the experience of mental health by clients and family members and by the community at large will be changed and how to measure those changes. After Ms. Hood and Dr. Oprendek made their presentations in the C/FM meeting, the clients and family members discussed specific measurement tools by age groups.

Ms. Hood noted that today was a concurrent DMH meeting/workgroup for the State Quality and Improvement Committee. This workgroup focuses on Medi-Cal, looking at different kinds of performance measures and indicators. She anticipates that this committee's work will eventually be integrated with MHSA efforts in order to provide a comprehensive quality improvement strategy.

B. Client and Family Member Questions and Comments

Clients and family members had many questions and comments about both Ms. Hood's and Dr. Oprendek's presentations. The questions are listed below followed by Responses from Dr. Oprendek.

Performance Measurements and Quality Improvement Indicators

- If the tool is geared toward accountability and performance standards, it needs to be a sharper tool, with sharper definitions of indicators.
  - **DMH Response**: There are many terms and definitions for indicators. While having different definitions can be a challenge, if the Department uses only one definition, the process may not be transformative. DMH will start small to find out what stakeholders really want from the mental health system and then define it. Working backwards will let everyone know what the ultimate goals and benchmarks are. It is important to focus on the concept rather than on semantics.

- Use "hope" as the biggest indicator of whether MHSA is succeeding. It cuts across all cultures and age groups. Do we have hope on the street? Does the system work to promote hope? Do individuals have hope in terms of their activities?
  - **DMH Response**: We want to promote hope.

- The DRAFT CSS Requirements includes a very broad list of outcomes. These should be tied to this workgroup's task with performance measurement.
  - **DMH Response**: Counties should know that DMH will tell a statewide story, and is using the stakeholder process to determine performance measures to tell that story. This will require standardization. The Performance Outcomes and Quality Indicators Section will have a Performance Measurements Committee of twenty people who are representative of California. It is fine if a county chooses to create their own measures; however, they will also need to use the measures developed by DMH in order to tell the statewide story.

- It seems that those indicators measuring quality of life are all objective quantifiable data. It is important to include subjective data, such as "How do you feel about your services?" and "How do you feel about your life?" These narrative type questions are valuable.

- When looking at performance measures, it is essential to consider social and environmental factors. Rather than simply looking at, for example, school attendance, it is important to explore in more depth the factors behind the numbers. Is bullying an issue? Is there a family problem? Is it safe to get there? Are there other factors that keep a child out of school besides the mental health component? Another example is the number of days incarcerated. There are so many factors that have little to do with the person: racial profiling, law enforcement training and attitudes, judicial perceptions, etc. Ignoring these factors places too much blame on the client.

- **DMH Response**: Absolutely. MHSA is about transformation. To identify influences on outcomes requires collecting a lot of information. When California has implemented Electronic Health Records, DMH can use more background information to illustrate the effects of these influences. It is not enough to say that some people are doing better on average. The quality improvement system must go deeper to see if the MHSA has an impact on individuals.

- The Recovery-Oriented System Indicators (ROSI) survey covers a period of six months. Other surveys only cover a period of one month. The six-month period is a better indicator in a person's life. For example, it would be difficult to measure arrests in a month, because the person in question might still be in jail at the time of the survey.
  - **DMH Response**: For MHSA purposes, DMH will design ways to measure that work in real time.

Communicating Information

- The feedback discussed at the client and family meeting will not be shared with the people who attend the meeting this afternoon. Clients and family members are sharing so many of our concerns at this meeting that will not be translated to the workgroup meeting. How can this occur?
  - **DMH Response**: DMH staff will remember it. There are people taking detailed notes that will be printed in a summary and posted on the MHSA website. Look at this as a transformational process. It would be better if DMH and stakeholders could talk daily in order to not lose the thread. Everyone's feedback is important.

- We need to influence the counties, not just DMH. Usually at the C/FM pre-meeting, clients and family members do not get to this level of detail.
  - **DMH Response**: Two recorders are typing in all the comments and this will be in the meeting summary that is posted.

- Q. What happens to these notes? Are they available?
  - **DMH Response**: The summary notes are posted on the website within five business days.
  - **C/FM Response**: I hope we can require the counties to read the summaries.

- Clear communication is essential throughout this process. Because the counties are moving so quickly, this information needs to be on their radar screens. There seems to be a silo around this stakeholder process and around the work being done at the county level.

Performance Measurement Chart Concerns

- Symbols are important. The Performance Measurement chart, in which client tracking and outcomes are at the bottom, seems to say that clients are an afterthought. Clients should be on top.

- **DMH Response**: This can easily be done. It was originally designed that way to reflect that clients and family members are the foundation of the system or pyramid.

- Add an explanation on the chart page that the design is a pyramid, in which clients are the foundation. This would allow people to read it without needing additional explanation.

- Show the different levels in vertical columns with clients on the left and the public on the right. Because we read left to right, this would show the relative importance of consumers.

- In the presentation, the middle bar of the Performance Measurements chart talks about satisfaction. The industry standard in the private sector is 80%. This type of measure is a blunt tool and must be sharper for MHSA purposes. Develop something about dissatisfaction, so this information can be identified.
  - **DMH Response**: What DMH currently uses to measure client satisfaction comes from nationally-derived measures used for federal block grant reporting. For MHSA, DMH wants to add indicators relevant for California. However, DMH cannot take away what is there, but can only add what is important to us. DMH and the counties will use the indicators to make quality improvements. A lot of what is currently used does not allow for deeper analysis. Therefore, DMH is exploring other information gathering methods, such as focus groups.

Cultural Competence

- Are these surveys translated into other languages?
  - **DMH Response**: They are currently available in Spanish, Chinese, Tagalog and Korean. DMH is relying on counties and other agencies to help with translation. Translation must often be done quickly because the surveys change so often. When the final versions are created, DMH will assure they are translated into a wide range of languages.

- The people who translate these surveys need to be sensitive to language. Sometimes translations use words clients and family members do not understand. If clients have to rely on program staff to complete the survey because they do not understand, the results may be skewed. Double-check translations with clients and family members.

Electronic Health Records (EHR)

- There is a common fallacy, called “after the fact therefore before the fact.” In terms of quality improvement, it means that DMH needs to measure things over time using many different factors. It is critical to build the case for comprehensive data collection.

- **DMH Response**: The EHR system would allow the capture of information that is already collected.

- What type of data will be shared from electronic records?
  - **DMH Response**: This is a huge issue. This stakeholder group will need to discuss this further. A lot of information is pertinent to individuals and will be governed by Health Insurance Portability and Accountability Act (HIPAA) and security. A lot of data that is not pertinent or tied to individual clients will also have to be discussed.

- Eating disorders are an elephant in the room that no one discusses, while children and youth die from them every year.
  - **DMH Response**: DMH is looking at all sorts of measures. The electronic health record should help with this.

Age Group Issues

- Could we have mental health awareness classes in grade schools and high schools?
  - **DMH Response**: DMH is exploring a number of ways to increase the information provided to children, youth and their families. At the public level, measurement tools are likely to include specific studies and evaluations. These have not yet been determined, as it is all uncharted territory.

- The Mental Health Association of Los Angeles (MHALA) has developed some good measures for children. Will DMH be looking at those?
  - **DMH Response**: Yes. Their wellness centers are in line with what DMH wants for MHSA. They use the SF-12 which has a mental illness perspective as does the Multnomah Community Ability Scales (MCAS). The measures are old and although they are recovery-oriented, they are not as focused on recovery as DMH would like. It would be better to look at the ROSI, rather than rely on an old perspective.
  - **C/FM Response:** Dave Pilon from MHALA has developed his own measurements that are more recovery-oriented and updated.
  - **DMH Response**: DMH will check on those, as staff believe more measures to evaluate are better than fewer. The Department is happy to look at any that stakeholders have to share.

- How can indicators for children and transition-age youth with eating disorders be developed? In terms of quality of life, recovery from eating disorders is slightly different from other mental health disorders.
  - **DMH Response**: Most indicators do not target specific conditions or diagnoses, but tend to cut across them.

- Transition-age adults are now being identified as baby boomers who are aging. Medi-Cal and Medicare are developing a fact sheet about them and services specific

to their needs. This group has some different characteristics than those who have gone before them.
  - **DMH Response**: Where to divide the adult and older adult age groups is a challenge, and is somewhat arbitrary.

- What is the size variation of the four age groups of children, transition-age youth, adults, and older adults?
  - **DMH Response**: Adults are the largest group, because of the wide age range (from about 18 to 65). Older adults is the smallest. Children and transition-age youth (16-25) groups are about the same size, although transition-age youth may be slightly smaller.

Specific Target Groups or Conditions

- Is there a way to assess if millionaires are satisfied with MHSA? Are they included in the stakeholders?
  - **DMH Response**: They are part of the community. However, they are not being targeted separately.

- There should be a specific standard of measurement for those people who have been diagnosed with mental health issues and have received only recovery services. It is important to measure the recovery of those who choose not to receive "traditional" treatment but only peer services. This information should be in a database.
  - **DMH Response**: DMH is working on this. Those who are part of the service delivery system will have one set of measures. Those who use peer support services will have a different set. It will be challenging to identify people who are not in the traditional mental health system as individuals for tracking purposes. However, it is DMH's intention to gain an understanding of the service utilization for this group.

- Jean Campbell did a self-help study financed by the Center for Mental Health Services. The report is due soon, although funding for dissemination seems to be an issue.

General Questions and Comments

- Can we have all MHSA information in binders or on a CD?
  - **DMH Response**: A lot of the information is on the MHSA website, http://www.dmh.ca.gov/MHSA. People have requested that the website have more organization. DMH is discussing this with vendors and Department IT staff.

- Everything rests on grassroots involvement and engagement.

- The scope of what we are working on is so vast. There are so many people who need mental health services.

Progress on MHSA

- Has DMH made a decision about releasing the supplantation requirements in draft or final form?
  - **DMH Response**: At this point, it is expected to be issued in final form.

C. Review of Feedback on Recovery-Oriented System Indicators

Clients and family members were asked to review the ROSI survey measures and to provide feedback about how they might apply for the different age groups. There are fewer recovery-oriented measures available for children and transition-age youth than for adults and older adults. Together the client and family member group brainstormed a substantial list of recommendations for additions, changes and formatting, by age group and across all age groups.

Children

- The survey is written for adults. Younger children would not understand the survey. If someone administers it, it would color the child's responses.
- Include a child-friendly rating scale about emotions, for example, using colors or other techniques that do not include words.
- Use questions the children themselves could read and answer, and include a section for adult feedback.
- The survey does not address education.
- Recovery is an area most children and their parents do not have a grasp on.

Transition-Age Youth (16 - 25)

Questions to Add

- Look at how the mental health system is helping transition-age youth with such issues as relationships, peer pressure and substance abuse.
- Ask a question about safe sex practices.
- Transition-age youth do not know enough about benefits they are eligible to receive, what kinds of jobs affect these benefits, and how their life relates to their benefits. Add questions to address these issues.
- Ask whether transition-age youth received an orientation to the adult system of care and support. Ask if they know what is ahead for them.
- Ask whether trauma issues have been addressed or whether the person has had an opportunity to have trauma issues addressed. By transition-age, this should have happened.
- Ask the question, "Do you know a place to get services without the fear of negative repercussions from parents or law enforcement, including substance abuse?"

- Under “place to live,” add “Are you happy at home?”
- The survey has very little about family relationships. Add more about family reintegration.
- Add a final question, “Are you interested in working with the county to improve the system?”

Survey Administration and Input

- A group of transition-age youth should provide feedback on the survey tool.
- Their peers or very young adults should survey transition-age youth.
- Administer the survey on line with “point and click” capability.

Adults

- Add a question asking, “Do you have hope?”
- Add a question from the DRAFT CSS Requirements about meaningful use of time and capabilities.
- Add a question from the DRAFT CSS Requirements about a network of supportive relationships.
- Ask more specific questions about how a person’s income is being helped, for example, through self-help centers which provide meals, bus passes, etc.
- Ask about what a person does when s/he has used all the income for the month and the month is not over.
- Ask more specific questions about housing issues: does the person own his or her home or share? Is housing adequate or substandard?
- Move Question 20 about staff pressure and threats and rephrase it to include “if I’m forced to take medications.”
- Add to Question 31 about staff respect, “Staff treat me with respect in terms of my life experience.”
- Ask how persons feel about their own recovery.

Older Adults

Stigma and Isolation

- There is special stigma for older adults that makes them feel they are not strong enough. Ask how stigma experience is addressed.
- Some staff transmit a sense of “writing off” older adults. Include a question about whether people feel valued by staff.
- Ask, “Are you afraid of retaliation if you answer these questions honestly?”
- Housing, transportation and isolation are huge issues for older adults. A survey for older adults could emphasize these and have less on employment or education.

- Ask questions about isolation, including nutrition and ability to obtain food because of isolation. Ask about the possibility of giving back to the community as a volunteer and opportunities for peer counseling.

Emotional Well-Being

- Ask how they are dealing with impending death.
- Ask how happy they are, and what services they think they need.

Family Issues

- Ask about integration of family, which could make the difference between dependence and independence. There is value in being able to stay in one's own home or with family.
- Ask questions about adult children with mental illness. Some seniors allow their adult children to not take medications, some of whom then become dangers to themselves or their families.

Benefits

- Address those transitioning from Medi-Cal to Medicare, so they know what services will change and affect their daily life.
- Ask questions about their knowledge and satisfaction with benefits.
- Ask if they feel they are on too many medications.
- Alzheimer's deserves special mention.

General Survey Issues

- There were several suggestions for how to frame the questions. These included:
    - Do not use negative questions that require double-negative responses.
    - Include negative questions so that the possible difference in the different phrasings can be determined. Negative questions can be important. Look at other wording issues to make them easier to answer.
- Group questions into categories such as housing, income, etc.
- There should be a written invitation for face-to-face feedback.
- The area for open-ended comments should be larger.
- Under "consumer-run programs," add a box for "not available."
- In the question about mental health staff ignoring client's physical health, add a line for more examples.
- Ask for more details and allow for an open response, for example, Question 14, about civil rights.
- Allow comments for each question, giving the opportunity for clients to say how they would improve the service.

- Add space for details. For example, in Question 31 about staff respect of a consumer's background, expand the list to include disabilities and gender identity. In Question 36, about the right to refuse treatment, have room for more information.
- In Question 20, about staff pressure or threats, include more departments. Pressure or force could come from a judge, not only mental health staff. Look at the components of the questions.
- There should be reminders about the services up to the day they are given. What staff are being referred to: professionals or peers or peer professionals?
- Need to clarify what is included in mental health services.
- A number of questions should be broken into a couple of different questions. For example, the question about housing and safety should be two questions: "Did they help me get housing? Do I feel safe in my housing?"
- Questions are vague in some respects; for example, over a six-month period, some staff are good, some not. In the question about whether mental health staff interfere, the answer would make it unclear whether this interference were a good thing or a bad thing for the client.
- Add specificity to some questions. For example, transportation can extend beyond a car.
- In Question 27 about consumers working at mental health agencies, specify in what roles. Otherwise, the answers can be misleading.
- Develop a more positive way to phrase questions, for example, "Increase wellness and wholeness. Keep families together and healthy."
- Attachment 2: p. 8 about individual outcomes uses all negatives for outcomes. For example, reduce suicides, reduce homelessness, reduce unemployment. Change to positive, for example, rather than reduce suicides, increase zest for life; rather than reduce unemployment, get and keep quality jobs.
- There is nothing about the two separate issues of recovery and wellness in the survey. Add questions: "Do you feel you are on the road to recovery? Do you feel you need more help to achieve? Do you need more services for recovery?"
- Add SSD/SSI as second question on medical benefits item.
- Are we planning to use this document as a model?
    - **DMH Response:** This survey is a tool the Federal Center for Mental Health Services is considering using as a requirement for the federal block grant. DMH wants to see if it meets the needs and interests for California outcomes. It is being used as a point of departure for MHSA discussions.

III. Workgroup on Performance Measures (1:00 – 4:00 p.m.)

One hundred four (104) people participated in the afternoon workgroup meeting.

A. Welcome, Introduction and Purpose of the Workgroup Meeting

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, welcomed the participants. She reminded participants of the

purpose of workgroup sessions: to focus on a specific topic and provide feedback to the department. After a presentation by DMH staff, participants would have the opportunity to ask questions and then together discuss issues raised by the presentation. Later, in order to obtain feedback from everyone, the group would divide into smaller groups, record their focused discussion and report back to the larger group.

Stakeholder Question: Capital facilities and IT are intimately connected to this topic. When will this component be discussed?
DMH Response: A specific date has not been set. It is expected to be in June.

B. MHSA Updates: Progress since April 5 & 6 General Stakeholder Meetings

Carol Hood, DMH Deputy Director, provided an update on progress on MHSA since the general stakeholder meetings in April. It is described in detail in Section I.C. on pages 2-3 of this summary. Additional stakeholder questions and comments and Ms. Hood's responses follow here.

Involuntary Services

- In terms of involuntary services, would a resident of an Institution for Mental Disease (IMD), be excluded?
  - **DMH Response:** That is exactly the direction DMH is heading in which all clients, regardless of their legal status, should be able to access MHSA services. The focus should be on the programs and services, not the status of the clients.

- Under MHSA, do IMD nursing homes and hospitals, such as Crestwood or Charter receive funding?
  - **DMH Response:** All funding goes through the counties according to their plan.

- In terms of involuntary services, there are many cases in which the client does not know s/he needs treatment. There should be an option for involuntary.
  - **DMH Response:** This is a perfect example of the range of opinions. The purpose of this update is to give stakeholders a flavor for how the thinking is in progress.

- In response to the comment that some people do not know they need treatment, we do not need forced treatment to continue. I spent fifteen years being overmedicated and misdiagnosed.

- Hold a separate meeting on involuntary services so that stakeholders can discuss the rest of the document without being bogged down in this discussion. Separate out that discussion, so that people can heal.
  - **DMH Response:** There is much controversy about the issue; the feelings run so high. We will work to construct a process to make sure there is time to discuss this.

Planning Process

- If the county plan-to-plan is approved, the county should be moving forward. If approval was conditional, does the county have to move backward in our planning process?
  - **DMH Response:** DMH is trying to avoid this situation but wants to see if the counties did what they said. Part of the approval process is to look at the planning process. It has not been decided whether this will be a separate process or part of the actual plan submission.

- DMH and MHSA say that the plan cannot be approved unless the county used a community process. But our county is saying it is going to do what it wants without going to the community.
  - **DMH Response:** DMH is checking up on these concerns.

- Is the community planning process the reason counties do not have a deadline for submitting their plans?
  - **DMH Response:** Yes, DMH wanted to give counties the opportunity to use whatever timeframe worked for them. The Department did not want to interrupt their processes and is not setting a timeline.

- Our county is trying to move quickly, and has been driven by the enthusiasm of our community. We have momentum, we are continuing to inform stakeholders, but we have to limit input to a degree and keep in mind that many want to see an early fall submission. For small counties, MHSA is not a lot of money, especially considering the many additional things they have to do that will consume a lot of the funding.

MHSA Components

- To develop a good system of care, counties need to include prevention and IT.
  - **DMH Response:** It has been a difficult balancing act that DMH has been struggling with throughout the implementation of MHSA. Counties need a comprehensive plan that takes everything into account, and yet it is impossible for DMH to create the guidelines all at once. Counties have to adapt as the process progresses. DMH is working toward the goal in which all requirements are integrated. However, everything must be done in steps, which makes many people uncomfortable.

- How different will the new CSS Requirements be?
  - **DMH Response:** It is hard to say. DMH is looking at that as a two-step process in the plan: counties need to insure that a complete community process was undertaken before the Department will review the rest of the plan. In addition, DMH is trying to streamline the requirements and trying to address the small county issues. The biggest conceptual change is that the Department is looking at three categories, not just system change and enrollment.

- Would you consider having a workgroup meeting on the new DRAFT CSS Requirements in southern California?
  - **DMH Response:** DMH will take this suggestion into consideration.

C. Performance Measurement Presentation and Discussion

Stephanie Oprendek, Ph.D., Chief, Performance Measures and Quality Indicators Section, made a presentation about performance measurement for MHSA, which is described in Section I.D. on pages 3-6 of this summary. Below are stakeholder questions and comments and her responses to them.

Confidentiality and Security Issues

- Does interoperability mean sharing information about clients between county and state?
  - **DMH Response:** Interoperability is an IT term meaning that different systems are open and can communicate with each other, to exchange data so that they can be aggregated. The data selection is guided by what people want communicated.

- Many clients are concerned about being tracked against their will. It seems that interoperability means client information will be shared without clients' knowledge. It is important to discuss what gets shared, with whom and why and whether clients will be able to agree or refuse.

- Peer providers should be involved in gathering information, such as using peer advocates from outside agencies, in order to obtain independent data. This would address fear of retaliation issues.

- Will this information be available to employers or others for misuse? Who will oversee security?
  - **DMH Response:** There is embedded security in everything DMH does. At the same time, it will always be a concern. It is essential to pay very close attention to ensure that confidential information is not given to those who should not have it.

- It is good to see a mechanism to gather input from staff. Who will collect this information from staff: one's supervisor? Will staff have union representation? What process will be used to move from the starting point to the integrated data collection? Providers should be included in the workgroup to discuss this issue.
  - **DMH Response:** DMH is in the process of forming a performance measurement committee. This committee will have providers and data entry staff as well as other stakeholders. DMH wants data collection to be part of the county or providers' business processes. At the same time, it is important to realize that not everyone will like whatever system is developed. The plan is to develop a system whereby counties can continue to use their proprietary systems and DMH and

other related agencies could pull data streams from those systems. It is likely that most of what DMH plans to capture is already what counties collect. This will be further discussed at the IT workgroup.

Wellness and Recovery Measures

- Thank you for including quality of life measures for clients.

- Include self-help centers in the public and community level. These are a source of peer employment.

- The presentation references evidence-based practices. There has been a general discussion about adding "values-driven," meaning those values identified in MHSA: cultural competence, wellness, and recovery. For example, acupuncture is not evidence-based, but might get people into care. There has also been discussion about adding promising practices. We live in a moving world, so fidelity to practices must be flexible.

- The Mental Health Planning Council offers a new resource called *Partnerships for Quality*. It could be useful for developing quality improvement activities. The paper describes the role of all the entities involved in performance improvement. The Planning Council is working on a recommendation to use the Institute of Medicine's *Crossing the Quality Chasm* and its six aims – health care should be 1) safe, 2) effective, 3) patient-centered, 4) timely, 5) efficient and 6) equitable – to form the framework for quality. Go to DMH website and follow the Planning Council publications links. This report will be posted within a few days.

- The presentation references episodic care and treatment. It is imperative that clients never be discharged or disengaged from the system into a vacuum. Clients at all levels of recovery need a network of support.
  - **DMH Response:** DMH agrees that disengagement should be in accordance with what is going on in clients' lives. It is noted because DMH wants people to have the choice to disengage.

Complexity and Cost Concerns

- There is concern about all the information that may be requested, especially for smaller counties. It is overwhelming. Look at ways to start off slowly so counties can begin. Balance the cost of data collection with what will be taken away from services.

- This is a very ambitious performance measurement process. Does DMH propose phasing it in using manageable implementation strategies? As described, the quality improvement component could overshadow the costs of services.
  - **DMH Response:** DMH definitely plans to phase it in. For larger scale indicators, special studies will be used. For individual outcomes, the Department wants to

develop technologies to streamline the process at the county or provider level, with less duplication of effort. The Department has a real interest in transforming how data are collected. California cannot transform the system using current data collection methods.

- It seems like there are two layers of evaluation: individual client data and aggregate data. It also looks like there will be other surveys, specific to clients.
  - **DMH Response:** DMH wants to tell a statewide story and will aggregate a lot of data. The surveys are only part of it. The Department is looking at individual progress toward recovery and at different models, including ones that are more interview-based. Ultimately an electronic health record (EHR) will be developed to capture the information. MHSA needs a bridge between what is currently available and what will be most effective over time.

- Prevalence is a complex issue. On one level, among Latinos who are new to this country, who come from a culture that values family and community, prevalence is about half the rate here. Community can make a difference. How would prevalence be used as an indicator?
  - **DMH Response:** Prevalence rates are based on surveys and statistical models: no one knows with any certainty what the rate is in a population. It is important to develop better models.

- It is important to use longitudinal studies rather than point of time.

Performance Measurement Chart

- Promote hope as an indicator. Put a circle around the entire Performance Measurements diagram and write, “Is each level promoting hope, or decreasing it?”

- At the public and community impact level, include reduction of use of jail as mental health treatment as a measure, rather than as an afterthought.

- Under the community awareness level of the Performance Measures chart, telehealth as a means of outreach will not work for hard to reach populations. Most do not have access to telehealth or computers to obtain that information.
  - **DMH Response:** DMH is attempting to use multiple ways to reach people. Outreach may also include direct contact into communities or isolated geographic areas.

- When discussing implementing outreach, make a note to include the community leaders of those populations. To include unserved populations, counties must go to their community leaders; it is the only way to reach them.

County Data Collection Issues

- Will the body that provides oversight for county accountability include clients and family members?

- **DMH Response:** There is a Department committee that reviews county applications. On the county level, the Board of Supervisors reviews county plans. Clients and family members should all be part of each county's stakeholder process.

- To whom will these performance measures apply: the enrolled clients or all the clients served in a county?
  - **DMH Response:** DMH envisions that initially the performance measures for individual client tracking will apply to enrolled clients only. Eventually they will apply to everyone who uses any component of the mental health system. The plan is to start out small, but over time, provide the same level of services and supports to everyone.

Integration of Data Collection

- Q. Will IT also track physical health?
  - **DMH Response:** The vision is to integrate physical and mental health, social services, and criminal justice as much as possible. The plan is to link systems, to allow other agencies to be able to access information to help people.

D. Table Talk on Performance Measurements

Stakeholders were asked to respond to two questions that would begin to address how to measure performance within the context of MHSA's vision. Participants divided into table discussion groups based on the four age groups: children and youth, transition-age youth (16 – 25), adults and older adults, and each group recorded their responses. At the end of the session, the groups reported back on their key feedback.

Please note: This section was transcribed from the written forms completed by each table during their discussion. The outcomes are listed with the corresponding measures suggested by the stakeholders within each group. Not all outcomes were accompanied by measures.

1. In your county's transformed mental health system, how will the mental health experience for clients and family members be different? How can these changes be measured?

Children

Early Intervention and Prevention

- Children will receive early intervention
  - *Measure:* Hospitalization rates
  - *Measure:* Involvement in juvenile justice

    - *Measure:* School attendance
    - *Measure:* Use AB 2034-like comparisons
- Engage children sooner, prior to problems
    - *Measure:* Percentage of high school graduates

Home and Community Services

- The system will look less like a "system," and more community-based
    - *Measure:* Number of point-of-contact persons for each child and family
- All children feel safe
- There will be increased home and community-based services, including: family treatments; wraparound services and one-stop services
    - *Measure:* Parents served in same system as children
    - *Measure:* Services are close to home: there is less out-of-county placement or at least regional opportunities
    - *Measure:* Number of children maintained at home vs. foster care
- Parents included in communications, so services are at least within reasonable driving distance within counties
    - *Measure:* Quality of Life indicators, such as communication with parents improved
    - *Measure:* Surveys for Quality of Life measures concerning safety, communication, and distance to services
    - *Measure:* Items on satisfaction surveys, such as "received services at a location of my choosing"
    - Separate measures for children and parents
- System will serve broader range of children in more normal settings, like schools
    - *Measure:* Utilization rates
    - *Measure:* Suspensions, detentions, dropouts
    - *Measure:* Grade Point Average (GPA), attendance
- There will be more services in home, not in clinics
    - *Measure:* Service locations

Other Services

- Enrollee-based interventions by mental health staff will be tied to an individual's plan
    - *Measure:* Improvement of individual behavior tied to a standard scale, such as Parent Stress Index, etc.
- Transition back to home will be facilitated with no interruption in services
    - *Measure:* Coordinated case management
- Flexibility will be built into service provision
    - *Measure:* Flexibility in data collection requirements, e.g., those who do not want to be counted do not have to be counted
- Long-term positive outcomes
    - *Measure:* There will be increased periodic follow-up
    - *Measure:* Families will know outcomes

Needs will be Met

- Integrated services will meet the child's needs
    - *Measure:* School attendance
    - *Measure:* Integration of reimbursement systems
    - *Measure:* Children spend less time in restrictive services
- Children's basic needs will be met
    - *Measure:* Collaborative case management
- Foster youth will obtain the services they need
    - *Measure:* Better data sharing between DSS, DMH and other agencies

Evidence-Based Practices

- Children will have increased access to evidence-based, values-driven practices with good measures to monitor
    - *Measure:* Special education placements
    - *Measure:* Family interactions
    - *Measure:* Mental health symptoms number and severity
- There will be more evidence-based practices

Risk Reduction

- There will be a decrease in high-risk behaviors, such as suicide, violence, detention, expulsions, alcohol and drugs
    - *Measure:* There will be more onsite services at schools
    - *Measure:* There will be fewer incidents like Columbine
- School programs will be available, as are programs in rural or small counties
    - *Measure:* School attendance
    - *Measure:* School performance (grades, achievement scores)
    - *Measure:* Behavior rating scales
    - *Measure:* Self-esteem measures
    - *Measure:* Parent satisfaction surveys
    - *Measure:* Youth satisfaction surveys
    - *Measure:* Tolerance for behavior will not mean at-risk children completely lose whatever structure they can have at school

Quality of Life

- Client status will improve and client will be included in planning and review
    - *Measure:* Ohio scales: improve and standardize
- There will be reduced stigma, including among ethnic minorities
    - *Measure:* Community attitudes and perceptions about mental health

Transition-Age Youth (16 – 25)

The groups noted their disappointment that no transition-age youth participated in the meeting to provide this feedback. It was recommended that special outreach be conducted to include transition-age youth, such as having transition-age youth attend workgroup meetings.

Needs will be Met

- Post Traumatic Stress Disorder (PTSD) will be considered a part of SED, and therefore a diagnosis under MHSA
    - *Measure:* The DSM will be transformed
- There will be integrated services for co-occurring disorders (developmental disabilities). Integration and availability of services will be mandated.
    - *Measure:* Existence of integrated services
- Youth will have good outcomes. Treatment plan needs will be addressed. Need to report outcomes in a contextual manner.
    - *Measure:* Number of youth living independently or with families
    - *Measure:* Number of youth employed or in vocation training or job placement services
    - *Measure:* Number of youth engaged in supportive services
    - *Measure:* Violence rate
    - *Measure:* Number of youth who become part of "adult" community, i.e., number obtaining driver's licenses
- Homeless transition-age youth will have improved outcomes
    - *Measure:* Counts of where they are, where they leave and move from one housing to another. Use AB 2034 measures.
    - *Measure:* There will be no barriers to access if person meets medical necessity.

Peer and Other Support Services

- There will be choice in services.
    - *Measure:* Youth have input on plan and have signed it.
- Services will be inclusive with opportunities that are non-treatment oriented.
- Peer services will be adequately funded.
- Funding will be tied to space created for transition-age youth peer programs.
- Peer support programs will be supported and funded, including paying peers.
- Wraparound services will continue for transition-age youth.

Quality of Life, Recovery and Wellness

- Life experience and personal narratives will be honored rather than viewing the client as a set of symptoms. Recovery comes from listening to life experience. Is the issue one of life experience or mental health related?
    - *Measure:* Personal narrative, including strengths, is included in assessment.
- People will be seen as individuals, not group.
- There will be a reduction of stigma.

- There will be a decrease in violence in youth's life.
    - *Measure:* Incidence of violence

Transition Services

- Young adults will be prepared to enter to adult system in a seamless or coordinated manner.
    - *Measure:* Creation or existence of transition-age youth treatment teams and transition plans
    - *Measure:* Number of youth involved with planning
    - *Measure:* Client can identify support system including adults, providers, case managers and physicians.
- No one will "fail out" due to service disenrollment. Once identified and enrolled, services will continue regardless of funding.
    - *Measure:* Number of youth failing out or lost to follow-up
    - *Measure:* Number of youth receiving services in youth and adult systems

Assessment

- The assessment process will be more inclusive including life assessment in order to properly serve and diagnose; personal narratives will be honored; strengths will be included in assessment; services will be included; consumers and providers will share power in the process, with opportunities for peer support.

Additional Questions

- Will there be coordination when tracking through different systems, such as Social Services and criminal justice?
- DMH or counties need to decide on initial focus, such as starting with client level outcomes first. There needs to be clarification for why a particular group is being served.
- Need clarification on how to track individual service plan goals.

Adults

Empowerment, Recovery and Wellness

- Clients will experience improved levels of empowerment.
    - *Measure:* Degree of empowerment, quality of life, inclusion in community
- Client will truly have control over his/her services.
    - *Measure:* Steven Segal at UC Berkeley measures "locus of control." These should be individual, community and provider levels.
- Clients will have open access to their records.
- Clients will have decreased experience of stigma and increase in hope, self-esteem, self-worth, and voice in community.

    - *Measure:* Monitoring of NIMBYism
- There will be a reduction in incarceration.
    - *Measure:* Number of successful diversions
    - *Measure:* Recidivism rates
    - *Measure:* Mentally Ill Offender Criminal Reduction (MIOCR) measurements
- Clients will have more employment.
    - *Measure:* Number of days worked, as volunteer, part-time, full-time
    - *Measure:* Level of responsibility and pay
- Clients will have meaningful activity.
    - *Measure:* Quality of Life measures
    - *Measure:* Value-based evidence
- System will support people to make healthy choices with regard to prevention and early intervention.
- There will be enhanced choices for clients including treatment models, choice of providers, and choice of discipline for provider.

Providers

- Providers will document on a daily basis progress toward clients' goals.
    - *Measure:* Random sampling
- Providers will have appropriate education and training.
    - *Measure:* Number of consumers in high school, community college, four year college, vocational schools or WRAP who are being trained as peer providers
- Clients will have competent clinical assessment at intake and on an ongoing basis.
    - *Measure:* Chart audits
- There will be effective incentives for psychiatrists to increase their numbers.
- Services will improve, including a longer time for providers to spend with clients.
- Home visits will be available on a 24/7 basis by counselors or mental health professionals. Sometimes a home visit from a mental health professional can prevent the need to 5150 a client.

Social Connections

- Clients will experience reduced social isolation.
- Consumers will increase their social contacts.
    - *Measure:* Survey review of recovery literature, such as Jean Campbell's work
    - *Measure:* Level of services used
- CMHS will see their job as helping people improve their social connectedness.
- Clients will have good choices in terms of community connections.
- Clients and family members will find common ground.

Community Impact

- There will be a reduction of NIMBYism, particularly related to homelessness.
- There will be an attitude shift from symptoms to recovery.
- There will be a prevalence of self-help services and a shift from recipient to helper-provider.
- Measuring community input on recovery is as important as mental health system impact.
- Community will have better understanding of "recovery" and all the personal facets of a person's life that are involved.

Services

- Client–run programs will become the norm.
    - *Measure:* Number of client-run programs
- Programs that transition clients to community will become a norm.
    - *Measure:* Clients' needs, wants, preferences to be identified upon admission
- Prevention will include working backward from a crisis and identifying what would prevent future crises.
- There will be integrated mental and physical health services
    - *Measure:* Measure if clients are receiving medical care
    - *Measure:* Wellness program, follow-up
- There will be a reduction in acute care in least restrictive environments
    - *Measure:* Number of hospital days
    - *Measure:* Movement from higher to lower level of care

Needs will be Met and Outcomes will Improve

- Clients will have permanent supportive housing.
    - *Measure:* Document housing status every time client meets with service coordinator
- Persons with mental health issues will have improved incomes and reduced poverty.
- There will be improved mechanisms for addressing poverty.

Additional Comments

- One group noted that this questionnaire and questions would be helpful to use with stakeholders as part of county processes.
- Provide incentives, e.g., free movie tickets for people when they complete surveys.
- Do not know how to ascertain whether changes would be a result of MHSA activities. Possibly survey community groups before and after presentations.

Older Adults

This group noted that there was no one-to-one correlation between experience and measure.

Service Integration and Access

- Mental health and physical health will be integrated.
    - *Measure:* Rate of institutional care
- Older adults will have access to integrated mental health and substance abuse treatment services.
- Service providers will provide more opportunities for service integration and to help clients develop natural supports.
    - *Measure:* Penetration rate
    - *Measure:* Outreach activities
- The service system will provide services through mobile outreach.
    - *Measure:* Proportion of clients served in integrated mental/physical health system
- An abundance of peer support will be available.
    - *Measure:* Older adult suicide rate
    - *Measure:* Client satisfaction (MHSIP Consumer Survey)
    - *Measure:* Access to peer support

Wellness and Recovery

- Counties will promote wellness
    - *Measure:* Number of hospital days for mental and physical health
    - *Measure:* Access to home health care
- Older adults will be offered activities for lifelong learning, employment, or creative pursuits of their own choice.
    - *Measure:* Living situation
    - *Measure:* Provision of respite care
- Older adults will have safe, least restrictive and appropriate supportive housing.

2. In your county's transformed mental health system, how will the mental health experience for community members at large be different? How can these changes be measured?

Children

Education and Community Awareness Efforts

- An anti-stigma campaign designed by a local constituency will be launched.
    - *Measure:* Outreach campaign that creates a change in penetration rates

- Motivational speakers will make presentations at schools.
    - *Measure:* Number of contacts post-presentation or intervention
- Increased research will be conducted on children's issues.
    - *Measure:* Studies that reflect intervention effectiveness and outcomes
- There will be reduced stigma. Entire communities will value mental wellness, through community awareness and education.
    - *Measure:* Anti-stigma campaign; Penetration rates
- There will be a new mindset of a continuum of health care, not an "us vs. them." There will be overall support similar to the support for cancer, with walks, etc. It will be part of a general "health promotion" with "one-stop" services, of which a larger number will be available, with no stigma for using them. Integrated mental health buildings in a community health center, including Child Protective Services, Communicable Diseases, etc.
    - *Measure:* Mental health equivalent of Ronald McDonald House
    - *Measure:* Mental Health Ribbon
    - *Measure:* One-Stop Shops are valued and accepted
    - *Measure:* Penetration rates
    - *Measure:* Value of mental health wellness and treatment, as measured by people's attendance; Utilization of voluntary services
- Community members will have increased knowledge of how to access services and how to address problems.
    - *Measure:* PTA-type meetings
- Communities will be more stable with less family disruption.
    - *Measure:* Levels of foster care and juvenile justice placement

Services

- Community-based agencies will be seen as resources to the community.
    - *Measure:* Utilization of early intervention, etc.
- All services in continuum will be more acceptable, including group homes.
    - *Measure:* Community attitudes
- Community-based services will be available.
    - *Measure:* Data focused on the services not the individual
- There will be greater availability of services.
    - *Measure:* Community indicators
    - *Measure:* Community partnerships
- Services will be integrated and providers will collaborate.
    - *Measure:* Joint trainings completed

Additional Questions and Comments

- How will data be used? Will there be rewards or consequences? Data have to be usable. Will there be benchmarks?
- How will this be useful to providers?
- Need to prioritize indicators. As described, there are too many indicators to collect, especially initially.

- Minimize the burden on clients, families and staff. Information must be meaningful to family and providers.
- Standardize tools wherever possible.
- Develop fidelity tools.
- Need to be aware of the difference between system transformation versus positive outcomes. Caution should be taken to relating outcomes to a truly transformed system.

Transition-Age Youth

Community Impact

- Community will experience decreased costs for incarceration.
    - *Measure:* Community will experience less gang violence
    - *Measure:* Community will experience less homelessness
    - *Measure:* Community will experience less hospitalization and involuntary commitments
    - *Measure:* Community will experience fewer teen suicides
    - *Measure:* Community will experience more school completion
    - *Measure:* Community will experience more vocational engagement
    - *Measure:* Decreased costs for arrests

Services

- Services are integrated at county and state level.
    - *Measure:* Multiple stakeholders are represented
    - *Measure:* Time sanctioned by agencies
- Peer clubhouse models of services are available.
    - *Measure:* Counties fund these services and spaces
    - *Measure:* Consumers use these services and spaces
    - *Measure:* Consumers rate them positively

Empowerment

- Consumers perceive power is shared; they have a say in their future.

Additional Questions and Comments

- Must have transition-age youth involved in setting performance measures.

Adults

Community Awareness and Impact

- With an effective 24/7 system, communities will feel safer.
    - *Measure:* Number of 5150s
    - *Measure:* Number of homeless with mental illness
    - *Measure:* Reduced arrests
    - *Measure:* Reduced assaults against clients
- There will be more training for and understanding by law enforcement.
- There will be reduced NIMBY-ism.
    - *Measure:* Better community acceptance
    - *Measure:* Education provided
- There will be reduced stigma.
    - *Measure:* Increased use of mental health services
    - *Measure:* Community education provided
- There will be acceptance of persons receiving mental health services.
- Confidence in mental health system will improve.
    - *Measure:* Trust levels
- There will be reduced homelessness.
    - *Measure:* Days in homeless shelters
    - *Measure:* Data collection from drop-in centers
- There will be reduced incarceration.
    - *Measure:* Number of bookings in jail of mental health clients
- There will be strict oversight of board and care facilities.
- Community housing will trend away from board and care facilities.

Services

- Police will have resources other than jail for mental health needs.
    - *Measure:* Number of 5150s
- There will be more places for people to go in the community that are culturally competent to diffuse crisis level in many situations.
- Services will be available to meet the needs for integrated, holistic care for dual-diagnosed consumers.
- There will be more shared housing.
- Developmentally disabled needs will be addressed.

Social Connections and Communication

- Family members and adult clients will find common ground with satisfaction on both sides.
- There will be improved dialogue between NAMI and clients.
- Connections between individuals, family and community will be improved and not threatened or harmed as a result of mental illness.

Additional Questions and Comments

- How would we know if measurement process is too much of a burden?

- How do we measure “comfort level” among systems, clients and community?
- Every problem becomes an opportunity for quality improvement.

Older Adults

The small group for older adults did not complete this portion of the discussion.

E. Next Steps

DMH staff will review the summary and the recommendations. The next two performance measurement workgroup meetings will build on the feedback provided today.

Stakeholder Comment: These workgroups do not have adequate minority representation. At every opportunity for input, please include cultural competence.

The summary for this meeting will be posted by Wednesday, May 11. The second workgroup meeting on performance measures is scheduled for June 16, and the final one is scheduled for July 18.